



## Orthodontic Continuation of Care Form

Member ID Number: \_\_\_\_\_

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of previous provider that issued approval: \_\_\_\_\_  
\_\_\_\_\_

Banding date: \_\_\_\_\_

Balance expected for Future dates of service: \_\_\_\_\_

Services remaining to be covered: \_\_\_\_\_

Additional information required:

Documentation listing services to be rendered, which may include ADA form.

If the member is transferring from another insurance or Medicaid program: a copy of original orthodontic approval.

If the member is private pay or transferring from commercial insurance please provide the original diagnostic photographs, radiographs and supportive documentation.